NC DIVISION MH/DD/SAS
MEDICAID SERVICES AUDIT
Fall 2007

AUDITOR INSTRUCTIONS

Protocol for selecting a sample: All events for the New Services Medicaid audit will be drawn from **paid claims** dates from March 1, 2007 – July 31, 2007. Service dates will include Feb. 1, 2007 – June 30, 2007. Twenty (20) primary and five (5) backup service dates per provider will make up the sample, for a total of 25 service event dates.

Use of Alternate control #s: If the provider found documentation/billing errors and repaid Medicaid for a service event audited prior to the date the list of records was sent to them, do not include the event in the audit. Replace it with an alternate. Start with control #21 and use the alternates in order.

Q1 – Evidence of service authorization or submission of request for authorization:

- If the provider does not have evidence of authorization (letter from VO, or the LME as allowable), check for service authorization in the ValueOptions printout that covers the date of service being reviewed.
- **If authorization is present or is listed in the VO printout**, mark Q1a as "1", and Q1b as "9". Overall rating for Q1 = 1.
- **If no authorization is present and is not in the VO printout**, ask for evidence of submitting the request, and rate Q1a as "0".
- **If valid request for authorization is presented with evidence that it was submitted to VO** prior to the date of service, rate Q1a as "0" and Q1b as "1". Overall rating for Q1 = 1
- **If no authorization and no valid request is evident,** rate Q1a = 0 and Q1b = 0. Overall rating for Q1 = 0.
- **If Q1a and Q1b are both rated 0**, enter the dates in Q11c. **FROM** is the first date when there was no valid authorization or request for authorization for that authorization period. **TO** is the last date there was no valid authorization or the date of the audit, if there is still no authorization.
- **Either Q1a OR Q1b must be rated "1" for the overall rating of Q1 = 1.**

Q2 – Service Order:

- Appropriate service has been ordered.
- As of the first use of the new PCP format on or after 6/1/06, Medicaid-funded services must be ordered by a licensed MD/DO, a licensed psychologist, a licensed nurse practitioner or a licensed physician's assistant.

- **As of the first use of the PCP format, old service orders are no longer in effect, services must be ordered via signature of the appropriate professional on the PCP**.
- Order is signed on or before the date of service.
- If the plan being reviewed is not yet on the PCP format AND was not required to be on it as of the date of service reviewed, the old service order format is acceptable.
- Per the first set of PCP Instructions, effective 6/1/06, the service plan needed to be reviewed and put on the PCP format **on or near the person's birthday. This was in effect from 6/1/06 – 7/31/06.**
- Per the second set of PCP Instructions, **effective 8/1/06**, the service plan needed to be reviewed and put on the PCP format at the next required review based on:
    - Needs of the person changing
    - Target dates
    - Change of provider
- Q1a. Dates: FROM is the first date there is no valid service order. TO is the date a valid service order went into effect, or the date of the audit.

Q3 – Service Plan is Current:

- The individualized service plan shall begin at admission and shall be updated / revised when the individual's needs change, when a provider changes, &/or on or before assigned target dates.
- Per the first set of PCP Instructions, effective 6/1/06, the service plan needed to be reviewed and put on the PCP format **on or near the person's birthday. This was in effect from 6/1/06 – 7/31/06.**
- Per the second set of PCP Instructions, **effective 8/1/06**, the service plan needed to be reviewed and put on the PCP format at the next required review based on:
    - Needs of the person changing
    - Target dates
    - Change of provider
- Version 1 of the PCP format was to be used for new plans between 6/1/06 and 7/31/06. Version 2 of the PCP format was to be used for new plans from 8/1/06 – 7/31/07..
- Target dates may not exceed 12 months.
- **Signatures are obtained for each required/completed review, even if no change occurred.**
- In order for the plan to be current and therefore valid, the authorizing signatures must be dated on or before the date of service if not an initial plan.
- Documentation of the legally responsible person, if not the parent of a minor, needs to be reviewed.
- Author of the plan and legally responsible person has signed the service plan (documented explanation if not signed or signed later).
- 3a. Dates: FROM is the first date the service plan is not valid. TO is the date a valid plan went into effect, or the date of the audit.

Q4 – Plan Identifies the Service Billed:

- The service for which the provider has billed must be clearly identified in the service plan.
- This question will stand on it's own and not be automatically rated "0" if Q3 / Service Plan is rated "0".
- 4a. Dates: FROM is the first date the service plan did not identify the service billed. TO is the date the service plan correctly identified the service billed, or the date of the audit.

Q5 – Documentation is Signed:

- Service note is signed by the person who provided the service (full signature, no initials).
- Signature includes credentials, license, or degree for professionals; position name for paraprofessionals, which may be typed, stamped or handwritten.
- If the signature does not include the credentials, license, degree or position, do not rate as "0" If all or many of the signatures for the provider are lacking the credentials then require a POC. If it is just one – remind them of the need to include the credentials.
- **If there is no service documentation for the date being reviewed, mark this question "6 = No service note". Also mark "6" for Qs 6, 7, 8, 9,10 and mark "7 = Provider name not available" for Qs 12, 13, 14, 15.**

Q6 – Service Note reflects Purpose of Contact, Staff Intervention, Assessment of Progress toward Goals

- Service Note is a full narrative service note (no checklists), unless the service definition specifically requires or allows another type of note, and must include:
    - Purpose of the contact as it relates to a goal in the service plan;
    - Description of the intervention(s) / activity / treatment
    - Assessment of person's progress toward goals / effectiveness for the individual.
- This question is not rating the quality or duration of the purpose, intervention or the progress toward goal statements, only their existence.

Q7 – Service Note Relates to Goals:

- Service note states, summarizes and/or relates to a goal or references a goal number in the service plan.
- The goal is not expired or overdue for review.
- If the goal in the note does not reflect the exact language or use the right number for a goal, review the goals in the plan to see if it fits with one of them.
- This question will stand on it's own and not be automatically rated "0" if Q3 / Service Plan is rated "0".

Q8 – Specific Service Definition Requirements are Met:

- Auditor reviews the service note and determines if the documented intervention meets the service specific requirements.
- Refer to attached list of service specific requirements.

Q9 – Service Notes and Plan are Individualized:

- Auditor reviews service notes around the service date audited to determine if notes are individualized.
    - Notes should vary from day to day and person to person, and be specific to goals in each plan.
    - The first record reviewed by an auditor may have to be revisited if consequent notes in another record appear to be the same.
    - Auditor reviews each service plan as it is presented.
    - Plans and goals/interventions in particular, should be individual to the person to whom the plan belongs.
    - Goals should not be so generic that they can be applied to any person served by the provider.
    - In cases where similar goals make sense, per the service provided, the listed intervention/strategies should be clearly individualized.

Q10 – Units Billed Match Duration of Service:

- Duration of service for periodic services must be documented.
- Units billed and duration should be an exact match.
    - If units billed are greater than units documented, it is out of compliance.
    - If units billed are less than units documented, it is NOT out of compliance.

Q11 – Documentation Reflects Treatment for the Duration of Service:

- Determine that the documentation provided for a specific date of service adequately represents the number of units billed
    - Did the activity reasonably take place in the time indicated?
    - Did the activity reflect “treatment”, not just ADLs, chores, etc. for the time indicated?

Q12 – Qualifications and Training

- Review personnel record of staff who provided the service.
- For QPs, verify both education and experience, per Core Rules requirements (see Justifications sheet).
- Review training documentation for each item listed on the Qualifications Checklist.
- All training elements must be met prior to the date of service.

Q13 – Supervision Plans:

- Individualized supervision plans are required for paraprofessionals and associate professionals.
- Review each supervision plan to determine frequency/duration of required supervision. If supervision plan is in place, rate Q13a = 1.
- Supervision plans must be implemented as written. Review documentation of supervision against the supervision plan requirements. If supervision plan was implemented as written, rate Q13b = 1.

- An agency policy on supervision, even if it includes frequency/duration of supervision may not be accepted in lieu of an individual supervision plan.
- If the supervision plan is not implemented as written, enter the dates of non-compliance in 13c, for example:
    - Supervision plan calls for 1/month supervision. Event date is March 12. Enter "FROM: March 1 TO: March 31, 2007" in Q13c.
    - Supervision plan calls for 1/week supervision. Event date is March 12. Ask what the work week is (i.e., Monday-Sunday). Look up corresponding dates for the week and enter in Q13c.
- Both Q13a and Q13b must be rated "1" to have and overall rating for Q13 = 1.

Q14 – Disclosure of Criminal Conviction

- Review documentation showing the provider agency required the staff who provided the service to disclose any criminal conviction.
- Most frequent place to find the disclosure statement is on the employment application or on a separate form/statement filled out during the application process.

Q15 – Health Care Personnel Registry Check:

- There may be **no substantiated finding of abuse or neglect** listed on the NC Health Care Personnel Registry.
- Health Care Personnel Registry check must have been completed prior to the date of service.
- 14a - Dates: FROM is the first date there was no Health Care Personnel Registry check (no further back than 7/1/06) TO: is the date the Health Care Personnel Registry check was done, or the date of the audit.

Comment Section:

- **Comment on/clarify any "0/not met" elements above.** For example, if Q5 is called "out", write #5 in the Comment Section and explain why it was called out of compliance.
- **Attach copies of documentation for "0/not met" and commendable elements. All items rated "0" must have a copy of the documents reviewed that resulted in the call of out of compliance. UNLESS it is rated "0" because it doesn't exist – i.e., no service plan, or no service note.** Make sure the comments explain the situation if no documentation is attached.
- Note and make recommendations regarding other service plan or service note deficiencies that are out of compliance with State rules other than the Medicaid required criteria above.
- Identify examples of excellence.
- If an alternate/back-up control # is used (starting with #21) because the provider found documentation/billing errors and repaid Medicaid for a service event audited prior to the date the list of records was sent to them, note this in the comments section and attach a copy of documentation confirming the date and amount of the payback for

the event excluded. Enter all “8s” for the control number that is excluded.

- Auditor must complete all sections of the audit sheet and will be responsible for acquiring all needed information.
- Place colored post-it flag on all "NOT MET" events; arrange in control number order and give to Team Leader for final processing. **Team Leader needs to review the audit tools before the provider leaves!**

NOTE:

- **Each question will stand on it’s own. None will automatically be rated “0” because a related question is rated “0”.**
- **If Q5 (signature on note) is rated “6” because the note is missing, also rate Qs 6, 7, 8, 9,10,11 = “6”. Qs 12, 13, 14, 15 are rated “7” (provider name not available).**